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ABSTRACT

A panel of four child life specialists debated one another regarding the best approaches to structuring and supporting child life play practice within the changing health care system. Question 1 was, "What is the most appropriate role of senior child life staff?" The traditional playroom-based focus provides an opportunity for experienced staff to establish rapport, assess children's understanding of hospitalization or illness, identify preferred coping methods, and observe social skills interactions in a non-threatening setting. Because of changes in the health care delivery system, more severely ill children are served in the hospital setting and therefore, the most important role of the child life specialist is to facilitate children's mastery of health care encounters, primarily through focused interactions with children and families which may be translated directly into improved patient care and patient satisfaction. Playroom management should be delegated to less trained staff and volunteers. Question 2 was, "Should the Child Life Specialist's role in play be non-directive or directive?" Non-directed play provides an opportunity for children to work through feelings that they identify and are prepared to handle, rather than having adults imposing specific themes based on what they think is relevant. However, because changes in the health care setting have resulted in a loss of long-term patient contact, only through guided play can the specialist enable psychological preparation and "working-through" play. These extreme philosophical and practical positions have implications for training students in child life practice. (KDFB)

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# Implementing Play in Hospitals: Values and Viewpoints

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Throughout students' preparation for work with children and families, a number of variables interact to shape their overall views of play and their ultimate application of play in their practice. These include the information they acquire about its benefits, the messages they receive from multiple sources about its importance, and the models of its use to which they are exposed. As educators, an important part of our role is to identify these variables and to try to understand their potential impact on student practice. This is true for the education of teachers of young children and for the professionals whom we prepare—child life specialists. Child life specialists are members of the pediatric health care team who work with children and their families promoting normal development

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and facilitating coping and adjustment to illness, hospitalization and health care treatment. This is accomplished through such approaches as use of play, preparation for impending medical events, and provision of support to family members.

For the 1995 Child Life Council Conference on Professional Issues held in Boston, we were invited to form a panel to examine critical issues regarding play in the practice of child life. We did so by inviting four currently practicing child life specialists to debate questions about the use of play in today's health care settings. Our goal was to highlight and examine how the dramatic and rapid changes in health care delivery have impacted choices made by child life practitioners in their use of play.

During the past decade, child life specialists have adapted their practice within a climate of unprecedented change in health care. At a time when the population of hospitalized children is more acutely ill than ever before, the average length of stay has declined dramatically. For the child life specialist and all other health professionals, this translates into far less time to work with much sicker hospitalized children. Parallel change has taken place in outpatient services. Increasing numbers of children now receive complex health intervention on an ambulatory basis. These circumstances, both inpatient or outpatient, provide limited opportunity for child life contact and intervention.

In planning the panel discussion, we developed two questions to generate active debate concerning the best approaches to structuring and supporting child life play practice within this new health care system. Each participant was asked to take an identified position on one of these questions and to develop that position into a brief paper.

The first question addressed by panelists relates to the tasks and functions most appropriate for senior or experienced child life specialists. More specifically, should the practice of these individuals have a traditional, playroom-based focus, or should they adopt a more diversified, "restructured" role with emphasis on specific, medically oriented interventions such as preparation for, or support during, procedures? Jim Eury Allen presented a viewpoint advocating the traditional role, while Tom Collins argued for the restructured role.

The second question concerns the type of involvement the

child life specialist should have in the play provided for children in health care settings. That is, should play be nondirective, with the adult following the lead of the child, or should play consist of the adult actively guiding the child through anticipated, challenging medical events? Caroline Boettcher addressed the first of these viewpoints, while Joy Goldberger argued for the latter.

By asking these questions, we intended to identify extreme philosophical and practical positions. Although current child life practice lies somewhere on the continuum between the extremes, there is considerable, and possibly increasing, variation in play practice among existing child life programs. In organizing this panel, we wanted to discuss and examine these differences because they have such important implications for how our students will understand and support play in their future work. As educators, we appreciate and understand how central the clinical internship is in determining a student's knowledge and practice related to play. The more we know about current thinking and practice in the field, the better positioned we will be to develop integrated and comprehensive coursework and programs.

## Question 1: What Is the Most Appropriate Role for Senior Child Life Staff?

**Viewpoint: Senior staff should have a traditional, playroom-based focus.**

While playing with playdough one evening on the rehabilitation unit with a small group of patients, I engaged in a conversation with eight-year-old Darnell. Darnell had been in the hospital for about five months with a sudden, acute illness that had left him paralyzed from the waist down. He was working hard at smashing playdough into the "fun factory" when I asked him about what special was going to happen tomorrow. He continued smashing the playdough and in a matter-of-fact way stated, "I am going home... and I don't want to go."

I grabbed my shovel and started to dig. "You don't want to go home after being here for so long?" Darnell continued to play with the playdough. He never looked up, vigorously cutting the dough "snakes" into tiny little pieces. I kept digging. "Is there a reason why you don't want to go home?" Darnell then started into the

story of his mom being a drug dealer. He explained in detail about how drugs and money came in and out of the house. I had spent considerable time with Darnell for five months, but he waited until the day before discharge to divulge his secret.

I use this example to illustrate the importance of experienced staff in a playroom setting. What if a volunteer, a new student, or an inexperienced staff member had failed to recognize the importance of his comment? What if this person had responded to the same situation by saying, "Well, of course you want to go home. All kids want to go home"? Would he have opened up? Would this person have read the cues that something else may have been going on?

Why is it essential to have experienced child life staff facilitating play in the playroom? Play is a window on development that permits us to look inside of the patient. By providing developmentally appropriate activities and toys for patients, trained staff can assess the child's understanding and, perhaps, his misconceptions of hospitalization or illness. They can identify the child's preferred coping strategies and observe social skills and patient interactions in a group. Without adequate training or experience, the student, volunteer, or novice staff member may overlook key aspects of development, fail to notice misconceptions, and miss the child's expression of coping skills.

Playrooms provide nonthreatening oases in a sometimes very threatening and strange health care environment. By providing a nonthreatening setting free of medical procedures, trained staff can see the patient in a child-oriented environment filled with familiar objects—a setting where children are most likely to be themselves. Because of this climate, staff can establish rapport with the patient, recognize verbal and nonverbal cues and signs of stress, and learn about the patient's style and personality. With the advent of shorter hospital stays, the time to establish rapport and trust with patients has diminished. Therefore, it is even more necessary that experienced staff be involved in such playroom interventions.

Without extensive understanding of children's reactions to stress, many cues may go undetected. The experienced staff person has the ability to establish rapport and recognize clues, such as Darnell's vigorous cutting of snakes. Recognition is the first step in the process; this is followed by intervention to address the identified issues (e.g., comments by the adult that "open the door"

for Darnell to talk about his feelings). A student, volunteer, or novice staff member may need assistance both in identifying the issue and in addressing it. The procedure-free playroom is the best place to assess the emotional status of children, for it is the most naturalistic area in the hospital or health care setting—the place where they are most comfortable being themselves.

We staff the playroom with experienced personnel in order that they may interact with patients through the mode of play. By providing play opportunities in this setting, there is much that trained staff members can accomplish. For example, they can facilitate normal development and behavior in the often strange hospital environment. They can provide medical play to assist children in their problem solving about, and mastery of, health care experiences. They can provide opportunities for a variety of forms of play—functional, dramatic, or goal oriented, parallel, group, or solitary. They can address developmental issues through play and encourage expression of feelings. They can observe family interactions within the playroom.

Volunteers and new students are typically effective in engaging children in normal, diversionary activities, such as board games or drawing. However, trained staff are essential for creating the *therapeutic* component of play. Experienced child life specialists are familiar with medical procedures and development and are knowledgeable about effective ways of communicating with children. Seasoned child life specialists have the ability to lead group activities while attending to individual needs. By staffing a playroom with a volunteer or student (who may lack the experience or knowledge of health care), children's misconceptions regarding the hospital experience may not be addressed in a way that facilitates their understanding.

The trained child life specialist can look through the developmental window to interact with the patient through the mode of play in a nonthreatening environment. When making decisions about staffing, it is essential to consider the placement of a senior child life specialist in this traditional playroom role. Only by placing senior staff in this, the most naturalistic environment that the hospital offers, can one maximize the opportunity to obtain accurate insight into children's development and to facilitate their coping with health care experiences.

Given today's tight resources, it is increasingly important to go back to the basics of a child life program and its roots in the playroom. In short, it is time to take "play" off of the "four-letter word" list. Instead of being "stuck in the playroom," perhaps we need to change our thinking to "having the opportunity to provide patients and families with the opportunity and space to play" in the health care environment.

**Viewpoint: Senior child life staff should adopt a "restructured" role.**

The question at hand is whether the experienced child life specialist should devote primary attention to management of the playroom and facilitation of the overall therapeutic environment or, rather, delegate playroom management to less-trained staff and devote greater attention to focused interactions. The preceding viewpoint argued the merits of senior staff adopting a traditional, playroom-focused role. This role is typically characterized by assignment of the child life specialist to a single inpatient, acute-care unit. This individual organizes and implements playroom activities and supervises volunteers and students who assist in the providing of play experiences for patients. A primary focus of this work is to build relationships with children through the use of appropriate activities. The child life specialist then builds upon those relationships to stimulate communication that in turn promotes mastery of the health care experience. A traditional playroom-based program such as this is typically available to all children in a given unit, without selection based on their emotional need, and receives no funds on a fee-for-service basis.

A "restructured" role for child life specialists differs from the traditional one in several important respects. Duties within the program are assigned by a careful evaluation of the skills and experience individuals bring to the program and by matching these qualities with the demands of various tasks. The overall supervision of playroom activities and of volunteers is given to personnel at the level of child life assistant. This assignment of responsibilities allows senior staff to devote their time to other activities commensurate with their training and experience. These activities may include scheduled interactions with individual patients, such as preparation for surgery or other medical procedures, as well as support during

these or other stressful events. Patients receiving these interventions are frequently identified and their needs prioritized through assessment by the child life specialist.

The evolution of child life to the "restructured" role reflects greater changes occurring in pediatric care. Even as the delivery of health care must respond to changing times, so must the profession of child life. Although there is certainly variation among health care settings, overall there has been an increase in the acuity level of hospitalized patients. This results from our greater ability to intervene with severely ill children than in decades past, as well as from the diversion of less severely ill children to other than hospital settings for their treatment.

As a result, the individual children we see in hospitals today are sicker than ever before. Moreover, children with profound medical problems represent a higher percentage of the patients on each unit. These children often have chronic illnesses and complex family issues. These children may not even be able to visit the playroom. Despite the acuity of their conditions, children are being discharged from the hospital more rapidly than in the past. At the same time, the roles of caregivers serving these children have changed significantly, with each providing more limited, specialized forms of care.

A number of other changes in the health care system have affected the practice of child life, some in a positive way. For example, hospital environments have become more child and family focused. Parents rooming in with their hospitalized child is accepted now as a standard of care. Parents are often allowed to be with their children during induction of anesthesia and in the recovery room following surgery. Our culture has changed, albeit slowly at times, in terms of parents and health care professionals encouraging active participation by children in their own care.

Even as the psychosocial environment of hospitals has improved, these institutions' fiscal resources have been stretched. Under constant pressure to constrain costs, hospital administrators are challenged to allocate their resources in the most cost-effective manner. In response, they seek to maximize the impact caregivers have on their patients, and they seek to facilitate leadership roles for staff members.

As child life specialists, we wear many hats in the course of our

work. Nevertheless, if we are asked to identify our primary role, the most likely response is that we are facilitators of the child's mastery of health care encounters. In the current health care climate, the crucial question we must answer for ourselves is, "What is the most effective method of providing this service?" In answering this question, we may discover that our approach to child life must change drastically, as some programs have already done. If our choice is to staff our program differently, to have less skilled staff provide playroom management and the most skilled staff provide "focused" interactions, then what are the benefits of this approach?

Focused interactions help define more clearly child life's role in the rapidly changing health care environment. How often are we asked, "What is child life?" If I am preparing a child with a fractured femur to receive a spica cast, the child, family, and staff easily comprehend my purpose. Focused interactions target outcomes that translate directly into improved patient care and patient satisfaction—outcomes that are measurable, documentable, and important to patients, staff, and administrators alike. Through focused interventions, child life professionals become more connected to specific health care teams (e.g., a particular subspecialty such as hematology/oncology). That team may then consider child life to be an integral part of their service. As the foregoing suggests, focused interactions are likely to be more easily defended in times of budgetary crisis.

A reality of health care today is that children are seen for shorter periods of time, have more medical intrusions during that time, and encounter a broader range of medical personnel, each for brief intervals. This situation has several implications for our practice. First, it increases the necessity for preparing children for the multiple, stressful episodes they face. It also decreases our opportunity to develop long-term relationships with children and families, the foundation upon which child life has built its practice in the past. Finally, the fact that children will encounter many individuals over the course of their health care experiences suggests the need to share our skills and methods of interaction with others on the health care team. As we provide focused interactions, we have a greater opportunity to model a style of interaction for others—one that is participatory, involving, and developmentally based.

It should be noted that play is not lost under the "restruc-

tured" model of child life. In fact, play is essential to this approach. It is the medium through which we assess children; it is the medium through which intervention is provided. Through "focused intervention," we assess the child and then pursue a course of action. General developmental and diversional play can be provided through child life assistants, who can be supervised by senior staff to provide an environment that is both safe and therapeutic.

We may accept the argument that focused interactions assist with staffing and program management, yet the question each of us should ask ourselves is, "How does this change affect the children and families we serve? Does it improve the care they receive?" A model that emphasizes focused interactions provides a greater opportunity for us to be with the children who need us the most at the time they need us the most. The acknowledgment of a child's birthday is important, but if preparation for the celebration must occur at the same time that we are needed to prepare a child for an imminent bone marrow aspiration, how should we spend our time? If we provide skilled, focused interactions and preparations, there is a greater likelihood that the "at risk" children will venture out of their patient rooms and test the waters of the playroom. Given the climate of health care today, it is time for child life to maximize our impact on the patient population we serve.

## Question 2: Should the Child Life Specialist's Role in Play be Nondirective or Directive?

### Viewpoint: The child life specialist should use nondirected therapeutic play

Nondirected therapeutic play is a valuable tool for child life specialists in many settings. Therapeutic play in general provides a means for communicating with children who have difficulty speaking directly about their concerns. The goals of therapeutic play are to foster normal growth and development, to give children safe opportunities to make sense of their world by exploring and problem solving, and to invite children to express their feelings about their experiences, whether real or imagined.

Two key elements in therapeutic play are the materials used and the role of the practitioner. Nondirected therapeutic play is characterized by the child as the active initiator of spontaneous

play. The adult, in turn, adopts the role of a participant-observer whose behavior is responsive to and guided by the child's actions. The focus of nondirected therapeutic play is for children to guide the content, direction, and pace of the therapeutic process, while practitioners take the roles of observer, mediator, and interpreter.

In nondirected therapeutic play, child life specialists carefully choose play materials for children but do not suggest how they are to be used. It is necessary to provide children with different types of toys, ranging from specific medical equipment to more open-ended materials such as paper and crayons, puppets, dolls, and clay, all of which allow for symbolic play. Giving children a choice of objects will offer them a sense of control and mastery, as well as provide them a language of choice with which to communicate. In contrast, directing the play by limiting the availability of creative toys or guiding children to act out themes that an adult has guessed may be of concern can be more detrimental than helpful and is not necessarily therapeutic.

A hallmark of nondirected therapeutic play is meeting children where they are developmentally. By assuming a less controlling role in guiding the play, child life specialists can help children reflect on and learn about concerns that arise from their play. It is important that staff actively observe children's spontaneous play to uncover what they understand about their own situations instead of presuming that they know what the children need to know. For example, if a child life specialist is too quick to show a child how a fingerprick is performed for a blood test by modeling the procedure on a doll, he or she may miss an opportunity to see how the child has imagined the experience. Perhaps this child thinks the doctor is going to take out all of his blood or that he will be painfully poked many, many times. These are things the child may not be able to verbalize while watching a demonstration of a procedure but can communicate through play with the doll and equipment. Perhaps showing the procedure to the child provides more information than the child wants to know or can understand. Perhaps this child only wants his mother to hold him while he looks away from the doctor. This child may become more fearful by visualizing what will occur. It is imperative that child life specialists follow the lead of the children they work with to help them cope with their specific situations.

Knowledge about child development can help child life specialists support children in age-appropriate ways. For example, younger children need a hands-on, motoric means of expression, while older children are more developmentally equipped, mentally and emotionally, to use symbolic and pretend play. But all children need available expressive opportunities in all modalities. A ten-year-old child may only be able to express his anger through pounding playdough, and a two-year-old child may need to provide herself a symbolic sense of security by covering up her doll with a blanket. The role of adults in nondirected therapeutic play, then, is to carefully watch children as they play, picking out themes that the children act out, and following their cues to assist them in assimilating those themes into their treatment.

Nondirected therapeutic play provides the children an opportunity to work through feelings that they identify and that they are prepared to handle. Within this play, adults do not impose specific themes based on what they believe to be relevant to the children at that particular time. The unstructured format allows the children to explore and express their own concerns as those arise. If child life specialists impose their own interpretations on children, they risk cutting off communication instead of fostering it by making children feel as if they are misunderstood. For example, even a seemingly supportive comment, such as "You must have been scared," can suggest to children that they may not be sufficiently competent to handle a situation. If the child life specialist listens instead to the child through such play signals as hiding or running away, he or she can help the child interpret personal actions and feelings by identifying the symbolic message. This child-centered approach places children in control by offering them a language for their expectations, fantasies, and fears, which adults can then interpret to support with further reflection and education.

In summary, nondirected therapeutic play is an open-ended approach of communicating with children that can be used for short- and long-term encounters. The intent of the therapeutic play will dictate the time and materials necessary. In the ideal situation, there is ample time for many interactions between children and child life specialists to establish relationships in which the children are comfortable with expressing their strongest fears. It may take time for children's fears to become conscious. Therapeutic

play, after all, is a *process*. I have, however, seen nondirected play used successfully with children in far less than ideal circumstances, such as in those anticipatory moments prior to being wheeled into an operating room.

Child life specialists need to remember that play is, after all, the way children learn about themselves and their world. It is not our job to directly tell them how to do it, but instead to support this important process.

**Viewpoint: The child life specialist should use guided play.**

I will state my central point circuitously: when caring for children in potentially stressful health care settings, choosing not to address impending unfamiliar or potentially challenging situations through guided play borders on negligent child life practice. This is not a statement I make lightly. However, I believe that the delivery of health care services has changed so dramatically that only a dramatic rethinking of child life values and practice is appropriate at this time.

Spontaneous play has served in a meaningful capacity for decades, and our intense valuing and enabling of such play recognizes the crucial role of both expression of and victory (even if only in fantasy) over overwhelming experiences. Historically, observing such play has guided our assessments and interventions. Times, however, have changed.

We have lost our previous "touch points" in health care settings. Sometimes, it seems, we can barely interact at all, much less rely on extended unstructured times in which children's emotional themes can unfold. Given these changes, we have two choices. Simply stated, these are to (1) address issues or (2) "not." Only if we choose the route of addressing issues through guided play can we enable psychological preparation and "working-through" play, and thus potential mastery for child and parents.

Through the research literature, we know that the value of psychological preparation and planned coping interventions has been repeatedly documented. I don't believe any other treatment approach demonstrates such consistent benefits. If we as child life specialists then choose to leave play to children's spontaneous interests, play may or may not address their medical situation. If they avoid play that relates to health care, then we deny the child

the opportunity for "stress-point care," with its repeatedly documented benefits.

Our goal is not to *demonstrate* the technical aspects of a procedure or to bombard a child's psyche with inordinate attention to the stressful situation. Guiding children to play about recent or imminent events that are likely to overwhelm them allows us to join them, explores more satisfying coping strategies, and helps them to enjoy a greater sense of mastery.

Children whose play most actively avoids direct expression or revisiting of difficult experiences may be just the children in greatest need of assistance. Procedures will occur no matter how vigorously children work to avoid them, and allowing this to occur without an appropriately sized dose of "planned coping" leaves children just as vulnerable and unprepared to master these situations as they were in the past.

Even if children choose to play about health care themes, they can't know how to play about impending, unknown situations and dilemmas. If, indeed, children select medical themes in their play, playing without professional adult guidance about what is imagined might actually be far worse than reality and serve to heighten anxiety. Similarly, if spontaneous play revisits past difficult health care experiences without guidance, unresolved conflicts and ineffective coping patterns may also be revisited and rehearsed without the benefit of trying out more comfortable, satisfying methods.

Furthermore, child life services are not likely to be available "later," when expressive play happens naturally. With briefer hospital stays, children's expressive play about challenging medical encounters will now occur almost exclusively outside the health care setting, after children return home. They are too sick or too overwhelmed to do this within today's health care setting. Both hospital contacts and clinic visits are typically too intense and too short for expressive play to casually unfold. In addition, reduced child life staffing, which has resulted in the necessity of fewer child life staff caring for more and sicker children in more locations, means that we must streamline our skills and work style and make a point of "getting to the point."

Now to state my point: only guided play can truly assist in preparing for, or working through, complex health care encounters. This is particularly true in our current climate, where those

health care encounters are brief and intense. This holds equally true in acute care, specialty care, and primary care settings. Only psychological preparation with planned coping offers the opportunity to rehearse new, or reinforce tentative, coping strategies. Enhanced coping has obvious benefits. It has the potential to impact the child's and family's evolving self-concept and their ability to cope in future similar situations. Perhaps less obvious is its impact on parent's perception of their own efficacy and of their child's resilience, again with great potential benefits for their interactions in health care settings and beyond. In addition, when serving in this capacity, child life specialists have the opportunity to interface with health care providers from all disciplines in shaping attitudes about meaningful health care participation.

This may mean that our role has changed. We may need to espouse a new professionalism. We must take a more active role in order to be proactive. We must commit to and work for more finely honed skills. At times, we may need to be less of a "friend" and more of an assertive guide for children, more of a mentor for parents.

In summary, allow me to let Elena speak for me. She is a four year old with a complex and rare genitourinary birth defect. We got to know each other when I was informed that she was about to be catheterized, that her parents were distraught and anxious and believed that clinic staff would never get her to cooperate, and that she would be traumatized. She did beautifully, thanks to preparation with planned coping. With many telephone calls from and some very specific guidance to her parents over the phone and a quick preparation session on the morning of her subsequent surgery, she coped well again. However, there were many complications during her lengthy recovery, and she became more stressed and anxious. In clinic visits, she came often, was "needy," and I seemed to have contact with her only in a general play, "group setting" kind of way. When, after several weeks, I was finally able to spend some time in focused, guided play, her mother reports that upon leaving the clinic Elena firmly stated, "Now *that* was good play."

## Implications for the Training of Students

Every student who will practice child life must address the question that Elena apparently answered through her comment—What is good play for children in health care settings? Is it supportive, developmental play offered by experienced personnel in group settings, or a more targeted, "focused" interaction that occurs around specific medical events? Is it play that is directed by the child and gradually unfolds under the child life specialist's watchful eye, or is it activity guided by the adult around potential medical stressors?

The viewpoints presented above represent the extreme positions that panel members were asked to defend. These forms of play are not mutually exclusive and certainly may be offered within a single program, although programs tend to fall toward one end of the continuum or the other. "Good play," simply stated, is play that most appropriately addresses a child's needs at a given point in time. Behind this simple statement, of course, are complex issues that challenge our capacity to provide such play. To blend the approaches discussed in the viewpoints takes an institution that promotes flexibility in the services it offers and that provides adequate resources for responding to the needs of individuals. It also takes child life professionals who have high-level skills. These individuals must recognize that the play needs of children in health care settings change not only day to day, but hour to hour. They must be skilled at knowing how to persist in interactions with children and when to hold back. They must be skilled in active involvement with children and at observation from a distance. Ultimately, the type and level of care they provide must be determined by their assessment of the unique set of variables affecting each child.

A fundamental challenge in the preparation of child life students is to foster these skills and to promote the capacity to make informed, defensible judgments concerning the use of play. This task becomes even more difficult and critical in an era when child life programs are routinely being asked to make choices about the services they provide and to justify the choices they make. It is a challenging task to prepare students to make choices about future practice at a time when the direction of health care is so uncertain. Nevertheless, there are steps that we as educators may take to help

students make more informed choices when the situation arises. We offer four such steps:

1) *Provide basic information on the value of play.* An underlying assumption of the viewpoints presented above is that play is of value to the lives of children. Students should be aware of the cognitive, physical, social, and psychosocial benefits of play to the lives of children. This awareness should be fostered through coursework and reinforced through assignments and experiences encountered in their field experiences.

2) *Help students recognize the forces impacting delivery of play in health care settings.* While personal beliefs may influence the practitioner's use of play in health care settings, other factors within the system may also affect how and when play is offered to children. The viewpoints illustrate a number of these factors. For example, economics will dictate the extent of resources that are available for play. Medical practice and the physical condition of children will influence their ability to participate in certain forms of play. Social and political factors within institutions will shape prevailing attitudes about the basic value of providing play experiences. Students must understand how health care systems operate and how these various factors influence the choices available to them.

3) *Help students evaluate the models of practice they encounter through their field placements.* As the viewpoints indicate, extremely divergent models exist for the practice of child life. During their training, students are likely at best to experience only a few of these directly. As educators, we must help them place their field experiences in a broader context. When encountering programs that either promote or seemingly de-emphasize play, we can help them examine the benefits and trade-offs of each approach.

4) *Foster among students an informed questioning of their practice.* Whatever one's beliefs about play and whatever mode of service delivery one encounters, it is certain that circumstances will change in the structure and practice of health care. Many of those changes will challenge the beliefs and practices of those providing services. Rather than being feared, this condition should be valued. We should encourage continual examination of practice among child life students. What is it that we are trying to accomplish? How are we going about it? Is our practice most appropriate, given the needs of the families with whom we work and the systems

within which we work? Through such an examination, we may find that we reaffirm commitment to old beliefs and approaches or that we need to change.

A final by-product of our participation in this discussion of play was our increased awareness of the value of gathering practitioners to exchange viewpoints. We seek to model for our students a deliberative and thoughtful approach to the practice of child life. Nevertheless, given the rapidity of change in health care, decisions about the reorganization of services are being made by individual programs with limited opportunity for discussion with colleagues elsewhere and with limited time to articulate the assumptions and rationale underlying the changes. This panel offered the opportunity for child life specialists to exchange viewpoints, to consider the circumstances they and other colleagues face, and to deliberately examine the manner in which their beliefs are put into practice.